DOCUMENTATION OF NEED

CASE NAME_____CASE NO._____DATE_____

ADDRESS_____TELEPHONE_____

APPLICANTS	DOB	RELATIONSHIP TO CASEHEAD	SEX F/M	INCOME TYPE/AMOUNT	PREGNANT? IF YES, DUE DATE	DISABLED? YES/NO	MEDICARE YES/NO	RESERVE TYPE/AMOUNT	CHILDCARE AMOUNT
1.									
2.									
3.									
4.									
5.									
6.									
OTHER HOUSEHOLD MEMBERS									
1.									
2.									

BUDGET COMPLETED/ATTACHED: YES ☐ NO ☐ RETRO ☐ ONGOING ☐_____

_____

1. Did you Explain: a. Reduction of Reserve Yes ☐ No ☐ N/A ☐ e. Income Producing Property Yes ☐ No ☐ N/A ☐

b. Transfer Yes ☐ No ☐ N/A ☐ f. Work First Agreement to sell real property Yes ☐ No ☐ N/A ☐

c. Rebuttal Yes ☐ No ☐ N/A ☐ g. DDS determines disability status Yes ☐ No ☐ N/A ☐

d. Burial Exclusion Yes ☐ No ☐ N/A ☐ h. Estate Recovery Yes ☐ No ☐ N//A ☐

2. Does the applicant have retro need? Yes ☐ No ☐

Applicant_____Month_____Amount_____Where_____

Applicant_____Month_____Amount_____Where_____

Applicant_____Month_____Amount_____Where_____

Applicant_____Month_____Amount_____Where_____

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Issued 10/01/02

MA-3205 Figure 1

3. Does the applicant have old bills? Yes ☐ No ☐

Applicant_____Month_____Amount_____Where_____

Applicant _____Month_____Amount_____Where_____

4. Does the applicant have any current bills? Yes ☐ No ☐

Applicant _____Month_____Amount_____Where_____

Applicant _____Month_____Amount_____Where_____

5. Does the applicant have anticipated medical bills? Yes ☐ No ☐

Applicant _____Month_____Amount_____Where_____

Applicant _____Month_____Amount_____Where_____

6. Based on observation, knowledge of client, and case record information, does the client have a condition listed below requiring the agency to obtain the necessary information?
Yes ☐ No ☐

A. Check the condition that applies:

☐ Blind	☐ Developmentally Disabled	☐ Homebound	☐ Otherwise clearly unable to obtain
☐ Deaf	☐ Unable to speak English	☐ Hospitalized	☐ Other_____
☐ Mentally ill	☐ Unable to speak or write	☐ Institutionalized	_____

B. Does the representative accept responsibility for obtaining information? Yes ☐ No ☐ Explain_____

7. Was the DMA-5097 completed? Yes ☐ No ☐ _____

8. Other agency records checked:

	Date Checked	No Record		Date Checked	No Record
Work First	_____	_____	SDX	_____	_____
Medicaid	_____	_____	SOLQ	_____	_____
Food Stamps	_____	_____	BENDEX	_____	_____
Services	_____	_____	ESC	_____	_____
			ACTS	_____	_____

9. Referral made? Yes ☐ If yes, state reason for referral below. No ☐

Referral to Medicaid ☐ Work First ☐_____

_____

_____

Worker's Signature_____ Date_____

MA-3205 Figure 1